

No. 2  
-1-4-41  
5-17-39

X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 16 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 242049  
Registrar's No. 2748

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6-14-41-6-29-41  
In this community Unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Jackson 048  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. Jackson County Home for Aged  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country

3. (a) PRINT FULL NAME Maceo Williams  
(b) If veteran. No name war  
3. (c) Social Security No. unk

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6 day 29  
year 41 hour 1 minute 25 A. M.  
21. I hereby certify that I attended the deceased from 6-14- 19 41 to 6-29- 19 41  
that I last saw him alive on 6-29- 19 41  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife. Antenawn  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased. Unknown  
(Month) (Day) (Year)

Immediate cause of death  
Acute Pulmonary Edema

8. AGE: Years Months Days If less than one day  
About 70 hr. min.

Due to Manic Depressive Psychosis  
Due to Cerebral Arteriosclerosis

9. Birthplace Texas  
(City, town, or county) (State or foreign country)  
10. Usual occupation Unemployed

Other conditions. 97  
(Include pregnancy within 3 months of death) 97

MOTHER FATHER {  
11. Industry or business \_\_\_\_\_  
12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Record Clerk  
(b) Address General Hospital #2  
17. (a) Burial (b) Date thereof 7-23-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation hosp  
18. (a) Signature of funeral director. [Signature]  
(b) Address City  
19. (a) 1-22/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) 0  
Address Gen. Hosp. #2 Date signed 7-2-41

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**